# Helping Those Who Need It Most:

# Low Income Seniors and the New Medicare Law

Testimony

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By

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Mr. Chairman and members of the committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation. I am also a former Administrator of the Health Care Financing Administration (1990 to 1992), now called the Centers for Medicare and Medicaid Services or CMS and a former chair of the Medicare Payment Advisory Commission, or MedPAC, from 1997 to 2001. My testimony today reflects my personal views as an economist and health policy analyst and also my experiences as Administrator of HCFA and chair of MedPAC.

The purpose of my testimony is to review the ways in which the new Medicare Modernization Act (MMA) impacts the lowest income and most vulnerable populations, the reasons why these provisions are so important and the lessons that can be learned from the experiences thus far with the prescription drug discount program and previous programs designed to assist the low income Medicare population.

Much has already been written about what's wrong with the new Medicare legislation. While there undoubtedly will be and should be modifications to the Medicare legislation, too little attention is being given to the positive impact the legislation will have on the lowest income populations. It is also important that any changes to the legislation occur after the full benefit has been implemented. As it is, it will take a Herculean effort on the part of CMS to implement the major provisions of the legislation in the time specified.

**The Medicare Prescription Drug Discount Card**

The Medicare prescription drug discount card began enrolling Medicare beneficiaries into the program in early May and began operations June 1. It is legislated to be in operation until December of 2005 and can best be thought of as a transition to the new Part D drug benefit of Medicare. According to recent CMS estimates, approximately 4 million people have already enrolled in the program, a remarkable number for the first two months of operation, compared to the experience with other new programs.

The prescription drug discount card was established as a way of providing immediate assistance to beneficiaries, available to all but intended for those without other outpatient drug coverage. The main purpose of the drug discount card is to bring the advantages of group purchasing to seniors who previously have had to "buy retail" and thus lower the prices that they have to pay. Purchase of the drug discount card is voluntary and can cost no more than $30 per year. Individuals may purchase only one Medicare-approved discount card.

In addition to the discount card, a cash subsidy of $600 is available to low income seniors who have no other drug coverage. Low income for purposes of the cash subsidy is defined as being below 135% of the Federal poverty line, which is about $12,569 per year for a single person and about $16,862 per year for a couple. These individuals do not have to pay an enrollment fee. An analysis by CMS has found that over a 7-month

period, low-income beneficiaries should be able to save between 32% and 86% over national average retail prices, when both the discounts and the $600 assistance are taken into account.

There are some very important features about the cash subsidy that add to the value of the subsidy and that may also serve as an important precedent for future policy change. The most important feature is that low-income individuals will receive the full $600 for 2004 even though the program only starts mid-year. Second in importance is that individuals who do not spend the full $600 may roll-over any remaining funds to 2005. The roll-over provision of unused funds, if applied elsewhere in current law such as to the flexible spending accounts used by many employees, would fundamentally change the "use-it or lose-it" feature that currently characterize these accounts.

The cash assistance is an important subsidy to the low-income population but it does not provide for 100% coverage even within the first $600 of prescription drug spending. As part of a deliberate policy statement, the Congress decided that low-income seniors should pay something for their drugs, even for the first $600. Individuals with incomes below 100 % of the poverty line pay 5% of the cost, which means a maximum of $30. Individuals who are between 100% and 135% of the poverty line pay 10% of the cost or a maximum of $60.

Because the prescription drug cards and cash subsidies can also be used by beneficiaries who have access to state pharmaceutical assistance program and/or special discounts that

pharmaceutical manufacturers make available to those in need, the potential assistance available to the most vulnerable populations who are not Medicaid-eligible is larger than most realize. In addition, Medicaid coverage remains in place for those who on both programs, the so-called dual-eligibles, until January of 2006.

**The Medicare Part D Prescription Drug Benefit**

Although a large amount of the media attention has been focusing on the prescription drug discount card, the actual Medicare drug benefit doesn't begin until January 1, 2006. The Part D drug benefit is a voluntary benefit that either will be delivered by private, stand-alone drug plans or as part of a comprehensive Medicare benefit delivered by private health plans. A government fall-back plan is authorized for any area that doesn't have at least two private-sector choices.

The standard coverage, for those above 150% of the poverty-line, involves a $250 deductible, 25% co-insurance for the first $2,250, 100% coinsurance for the next $3,600 (the so-called "doughnut-hole") and catastrophic coverage for any spending above that amount. Catastrophic coverage is defined as a 5% co-insurance or $2 for a generic drug/$5 for a branded drug co-payment per prescription, whichever is greater. In addition, there is a monthly premium, which is estimated to be $35 per month in 2006. The thresholds are indexed to grow according to the growth in per capita Part D drug spending.

The new Medicare law provides substantial additional help paying for prescription drug costs for low-income individuals who also have low assets. The greatest assistance is provided for people on Medicare who also have full Medicaid benefits, the so-called "full-benefit dual eligibles". Institutionalized dual eligibles (i.e. nursing home residents) have no payments. Dual eligibles below 100% of the poverty line pay no premium, no deductible and a small co-payment of $1 per generic or $3 per brand name prescription, up to the catastrophic level of coverage. After that, they pay nothing. Dual eligibles above the poverty line have similar assistance except that their co-payments are $2 per generic and $5 per branded name prescription.

People on Medicare with incomes below 135% of the poverty line and with limited assets ($6,000 per individual or $9,000 per couple) have the same assistance as dual eligibles that are above the poverty line. That means they have full coverage except for the $2/$5 co-payments.

People on Medicare with incomes below 150% of the poverty line and with slightly higher assets ($10,000 per individual or $20,000 per couple) have a more complicated assistance package. They pay a sliding scale premium (the amount depends on the premium cost of the plan they choose), $50 deductible, 15% coinsurance up to the catastrophic coverage and co-payments of $2 per generic and $5 per branded drug thereafter.

**The Importance of the Low Income Assistance Provisions**

Since the passage of the Medicare Modernization Act, there has been a lot of criticism leveled against the bill because of the gap in coverage after the first $2250 in spending and very little attention paid to enormity of assistance being provided to the low income population. Concern and criticism has also been raised about the dual-eligibles and whether they will get as much coverage after the bill is implemented as they had been getting under Medicaid.

There is at least some irony that prior to the passage of the bill, many of those now raising concerns about the dual eligibiles had been pressing for Medicare to take precedence over Medicaid. The legitimacy of these concerns won't become clear until after the regulations are written that define many of the specifics regarding the behavior of the free-standing drug plans including the required classes of drugs that will be made available to all beneficiaries and also until it becomes clear how state and pharmaceutical assistance programs adapt to the changing environment that follows the implementation of the Part D drug benefit.

What does seem to have been forgotten is that there have been a lot of problems with pharmaceutical coverage for dual eligibles all along. Under the new Medicare legislation, dual eligibles will have an entitlement to drugs and states won't be able to impose arbitrary restrictions on the number of prescriptions, both of which states could and did do under Medicaid. Since prescription drug coverage has been an optional

benefit under Medicaid, there has been no guarantee as to what states would make available. Some states had quite restrictive prescription drug benefits in terms of the allowed numbers of prescriptions per month or refills per year and at least 16 states used preferred drug lists combined with prior authorization provisions.

Although it is true that dual eligibles may not be guaranteed as complete drug coverage as they had in the most generous states under Medicaid, it is certainly possible that these same states will provide additional assistance at their own expense. The states can expect to achieve some savings as a result of the new Medicare law (although not as much as they would have if there hadn't been a maintenance of effort provision in the bill) and may therefore choose to augment the benefits made available to the dual eligibles. In a recently released study by PricewaterhouseCoopers for the Alliance to Improve Medicare, they estimate that the new law will pay for 98% of the spending by dual-eligibles even without supplementary support by the states.

The benefits to the remaining low income beneficiaries are very substantial and will mean that most of their prescription drug expenses will now be covered by Medicare. In the same PricewaterhouseCoopers study, the MMA is estimated to cover 96% of the prescription drug costs for beneficiaries below 135% of the poverty line who meet the relevant asset tests and 85% of the total prescription drug costs for beneficiaries that are below 150% of the poverty line who meet the asset limits for that group.

To put the spending of the MMA into perspective, this means more than 40% of the new Federal spending will be for individuals who are below 150% of the poverty line. Without the legislation, the PWC study estimates that 27% of these low income beneficiaries would have had no prescription drug coverage in 2006. With the new legislation, 65% of the low income beneficiaries (without Medicaid) are expected to spend less than $250 per year, with the median out of pocket spending expected to be about $200 and the mean about $725.

**Lessons to be learned**

The prescription drug discount card has been in effect for less than two months but there are already some lessons to be learned and more than will become clear as the year continues. Reaching and enrolling low income populations has always been difficult. This was true for the Medicare savings programs, the Medicare Qualified Beneficiary (QMB) and the Selected Low Income Beneficiary (SLMB) programs and also for the state Children's Health Insurance Program (SCHIP). This history actually makes the enrollment of 4 million seniors in two months quite remarkable.

Identifying and enrolling people in the transitional cash assistance program will be helpful for understanding how to reach the potentially-eligible individuals for the low income subsidy in the Part D benefit. States need to work together with the Federal Government to help make this happen better. The automatic enrollment strategy that has

been adopted by Pennsylvania and New York represents one such strategy and can be requested by other states but it raises other issues in its own right.

Out-reach programs conducted by state agencies on aging, the churches, advocacy groups and other means of reaching low income populations have had some effect in the past and should be pursued here. The President's 2005 budget has assumed a very successful rate of low income enrollment: 10.9 million out of a potential 14.5 million enrolled in 2006. I am not aware of any program that has achieved that high a rate of enrollment that quickly. It will represent an extraordinary achievement if it occurs.

CMS has already started modifying how information is presented for the discount cards, the type of information that is available on-line and the amount of time that it takes to connect with the 1-800 number. The Agency's ability to respond to problems as they arise portends well for the future.

**The Importance of *Not* Introducing New Legislation Before 2006**

There have already been calls for modifying the MMA, because of real or perceived inadequacies in the MMA or other concerns about the legislation. While there are undoubtedly many areas that will need to be modified over time, it is vital that CMS be allowed to proceed with the legislation as it is now written so that the Part D prescription drug benefit can start as of January 2006. To make changes during the next year is to seriously risk the start date. As is shown in this and other testimonies, delaying the

current legislation would have a serious and negative effect on the lowest income beneficiaries.

Many in the public have complained about the January 2006 start-date of the Part D benefit. These complaints are usually made by people who do not understand the large number of operational decisions that need to occur and the implementing regulations that will need to be issued prior to November 15, 2005, the date when Medicare beneficiaries are scheduled to begin their enrollment of the Part D benefit. These decisions relate first, to the provision of a new benefit using a new delivery system housed in a new center in CMS; second to a series of changes to the outpatient drugs already covered in Medicare under Part B; and third, to payment adjustments and other modifications to Medicare providers. Finally, CMS continues to have a number of obligations to fulfill from previous legislation as well as its other program responsibilities.

All of this work needs to occur during a period when there has been an unusually high level of turnover in the senior career staff of CMS, along with all of the uncertainties and change associated with an election period. Fortunately, CMS will not have to go through this activity with interim leadership. The confirmation of Dr. Mark McClellan last March as the CMS Administrator provides an important source of stability and leadership to CMS.

The early results of implementing the MMA have been promising. The appropriation of $1 billion to CMS and $500 million to the Social Security Administration to implement

the legislation is recognition of the daunting challenges associated with the MMA. The Congress would do well to let CMS proceed without further change until the Part D benefit is in place. This will permit CMS to proceed with its implementation strategy, will permit seniors to receive their promised benefits and will still allow the Congress to enact further change as it deems appropriate.

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